Welcome to Open Enrollment for Plan Year 2016. Today we will review the health plan options and changes for you to consider as you pick your health care coverage for next year.

State of the Plan

- The SEHP has been using Reserve Funds to buffer cost increases
- We are close to the Plan's Target Reserve
  - Plan expenses must now be covered by Plan revenues
- The SEHP's trend was larger than expected in 2014 at 7.5%
- Trend is made up of increased plan utilization & cost increases

- We begin by reviewing the State of the Health Plan. Over the last few years the plan has been spending down the reserves in excess of this target reserve. This spending has buffered the plan from some cost increases.

- The health plan actuaries have set our target reserve at approx. $59 million. This is the amount of money they have determined is necessary to meet the IBNR – incurred but not reported claims allowance and an allowance for claim fluctuations.

- Going forward, health plan expense will need to be covered by the health plan revenue. This will affect some of the health plan choices we will be discussing as we look at the Health Care Commission's decisions.

- The health plan trend, which is made up of plan utilization and increases in cost, went up at a higher than expected rate last year. This means the plan spent more for services than what was expected based on prior experience. Health plan trend is a factor in determining the amount of money that will be needed to fund future health care costs of the plan.

The SEHP trend drivers included:

- Increased utilization of emergency room
- Increased utilization & health care costs for inpatient care
- Increased use of physician services
- Price increases on prescription drugs

The driving factors behind the increased health care trend for the plan included:

- Increased utilization of emergency room
- Increased utilization & health care costs for inpatient care
- Increased use of physician services
- Price increases on prescription drugs

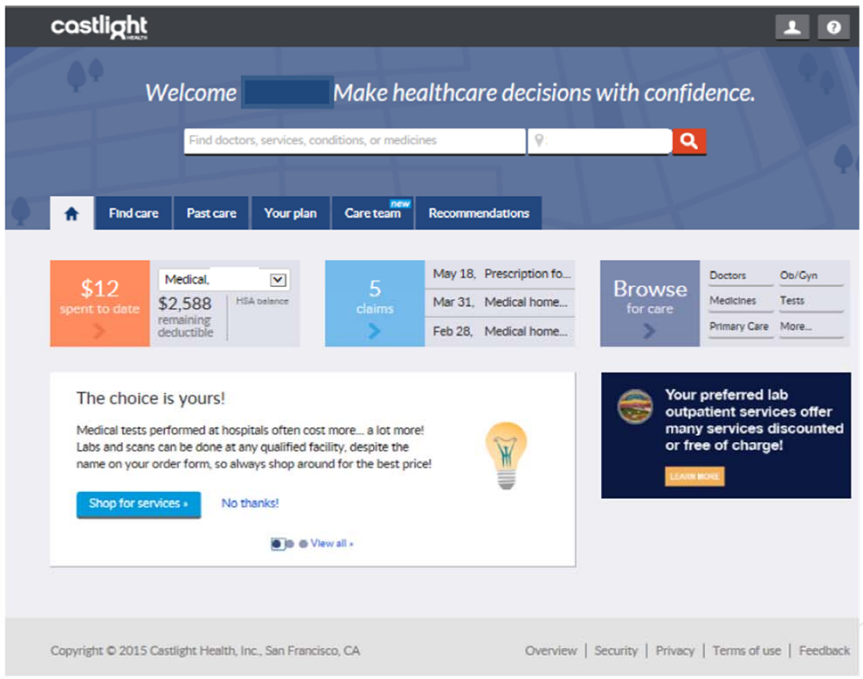
The SEHP has some tools that you can use to help reduce the cost of health care services while maintaining high quality service. High cost service does not necessarily mean it is also higher quality. So let's look at some tools you can use to review cost, quality and health information before you have services performed.

So it's Wednesday night at 10 p.m. and you are feeling poorly. Should you go to the emergency room or wait and call your doctor in the morning? Not sure? Call Nurse24 and speak to a health care professional that can assist you in making the best choices for seeking services.

Nurse24 is a benefit of the HealthQuest program and offers you access 24/7 - 365 to call a nurse and ask questions about your health and health care services at no cost. You can access Nurse24 by calling the toll free HealthQuest number on the magnet you receive every year about the program and selecting option 2.

Castlight Health

www.mycastlight.com/SEHP

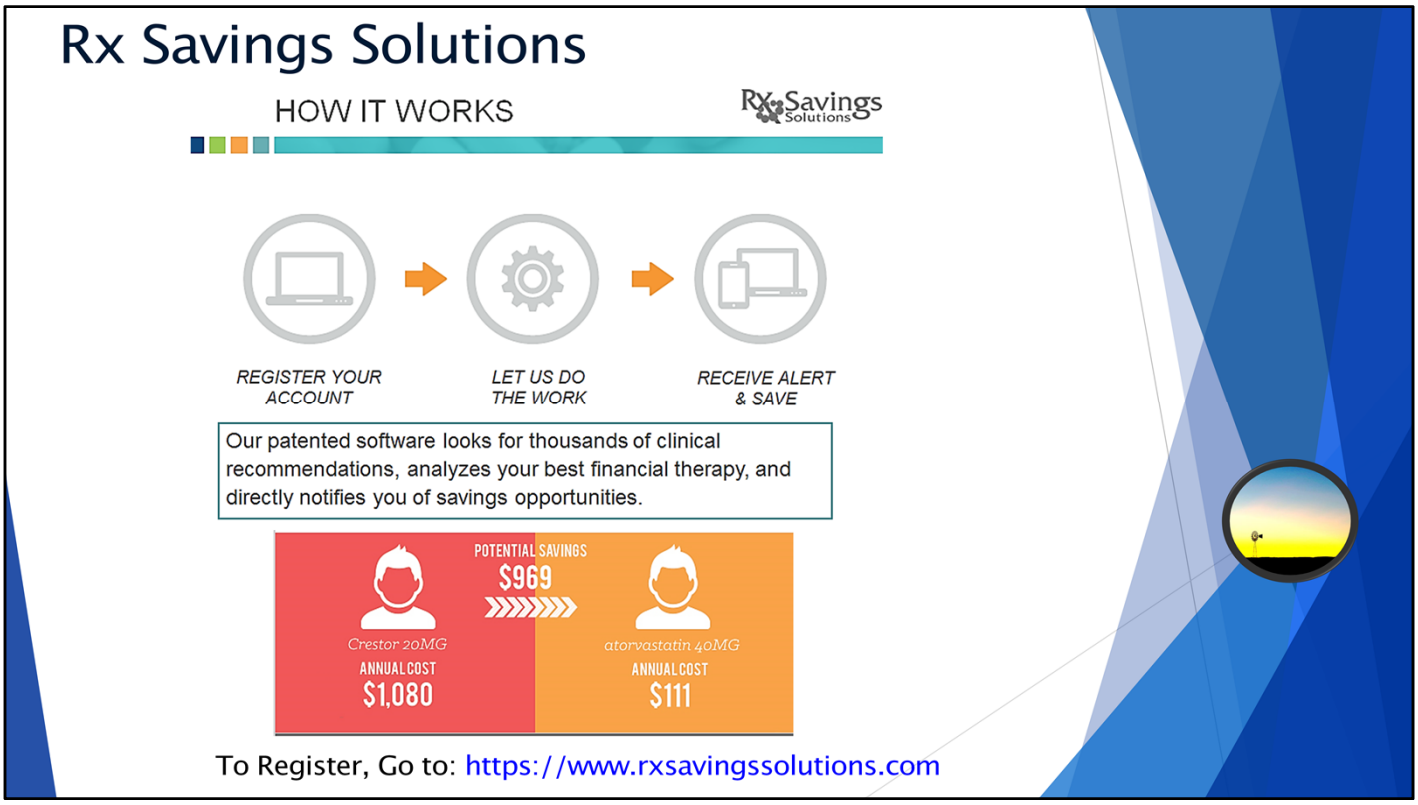


Your doctor has recommended that you have an MRI? Want to know what that might cost before you have it done?

Castlight Health is a web tool that you can access on your computer, tablet or phone that provides you with cost and quality information for network health care providers for your plan. You will be able to review your current deductible and Out of Pocket (OOP) for the year and review your past health care claims with the SEHP.

Shopping for services or providers is easy. Search by condition, location, quality or cost and the website will provide you information to assist you in finding high quality services at the lowest cost. The same service may have different costs so you can shop for services like MRIs and other scans.

Quality information is also presented from nationally recognized sources such as CMS, Leapfrog and more. By clicking on a provider's name, you can learn more about them, such as how long they have practiced, where they went to school and other information about their practice. You can also rate your providers and see provider ratings from your fellow employees shown in the comments area.



Ever heard anyone say, I can't believe what my prescription drugs cost me each month? Well, if you think your cost is high, remember the State pays the larger share of the cost of your preferred prescriptions and a significant amount on many non preferred prescription drugs.

How can you find out if there are other options that will maintain your health but cost less. That is where Rx Savings Solutions comes into play. Rx Savings reviews your drug spend and looks for ways to reduce your cost. If they find an opportunity for you to save money, they will reach out to you by email, text or phone and alert you to a savings opportunity. You can then log in to their site to learn more or call their customer service center and speak to a pharmacist or pharm tech about your options. Rx Savings can't change your prescription, only your physician can do that, but they can arm you with the information to have a conversation with your doctor about your options.

Recently, an employee notified the health plan that Rx Savings had helped them save $800 a month on their prescription costs. That is money that stays in your pocket each and every month.

HCC 2016 Decisions

- HealthQuest Rewards Program Changes:
  - PY 2017 premium incentive discount is $240 per year
  - Updated the credits for activities for PY 2017
    - Attending a health screening event now worth 5 credits
    - Non tobacco user credit will be populated from the Health Assessment

Beginning with the next HealthQuest Plan year which starts November 16, 2015, the HealthQuest premium incentive discount will be $240 annually or $10 per pay period for the standard 24 pay periods with health plan deductions.

The credits awarded for activities have been updated for PY 2017. More information on PY 2017 will be provided once the new plan year launches.

HCC 2016 Decisions

- Plan C premiums will be adjusted to reflect the true cost of coverage
- Coverage tiers that include spouses will be adjusted to reflect the true cost of covering spouses
- Dental premiums will be adjusted for dental trend
- Coverage will terminate on the last day of employment

As the HCC reviewed the plan for PY 2016, items that had previously been funded using reserve funds will now need to be paid for using plan revenue.

- The premium of Plan C has been subsidized to encourage enrollment but now will be increased to reflect the true cost of the plan.
- Employees covering spouses will see the cost of their coverage increase next year as the plan has not been charging enough premium to cover the expenses associated with covering spouses.
- Dental premiums were adjusted to reflect the cost of providing dental coverage to dependents.
- Once an employee terminates employment, their coverage in the health plan ends on that date.

HCC 2016 Decisions (cont'd)

- Plan Design Changes:
  - Plan A – Increased office visit copays by $5
  - Plan A – Increased network deductible to $400/$800
  - Plan C – Increased deductibles to $2,750/$5,500
- Pharmacy Coverage Changes:
  - Certain non preferred medications no longer covered
  - Nasal steroids are moving to the Discount tier

- The HCC voted to increase the cost of office visits under Plan A by $5 and to increase the network deductible by $100 for an individual and $200 for a family plan.
- Plan C had a deductible increase of $150 for an individual and $300 for a family plan
- On the pharmacy program some non preferred drugs and nasal steroids will no longer be eligible for payment. Removing these non preferred drugs will allow the plan and the members to benefit from improved pricing on the preferred drug options. As non preferred drugs have a higher cost of 60%, you want to maximize your benefits by using the preferred and generic options. There are preferred options available. We will review those changes in the next few slides.

Drugs No Longer Covered as of 11/1/15

- Non Preferred Antispasmodics
  - Oxytrol
  - Sanctura XR
  - Toviaz
  - Detrol LA
- All Non Preferred Diabetic Test Strip brands
  - Members will have an option for a new meter that uses preferred test strips at no cost from Caremark
- Letters have been sent to members
- Rx Savings will be reaching out to members as well
- Complete list of affected drugs:

http://www.kdheks.gov/hcf/sehp/BenefitDescriptions/CVSCaremark/RxDrugCovChgs.pdf

Non Preferred Diabetic test strips and antispasmodics will be removed from coverage as of November 1, 2015. Members using these items received the first communication from the plan last fall encouraging them to move to a preferred product. Free diabetic meters were offered to help members move to a preferred test strip. Additional letters and communications will be occurring between now and November 1 to encourage these members to talk to their doctors about using a preferred product. After November 1, members will need to have their physician complete a prior authorization substantiating medical necessity for the plan to continue to pay for these products.

Drugs No Longer Covered as of 1/1/16

- Some Non Preferred drugs will become non covered 1/1/16
  - Generic & Preferred Brand options are available
- Members taking these drugs will be notified by letter
- Rx Savings will also be reaching out to members
- A complete list of affected drugs is available at:

  www.kdheks.gov/hcf/sehp/BenefitDescriptions/CVSCaremark/2016-NonCoveredPrescriptionDrugList.pdf
- An appeal process through Caremark is available when remaining on the Non Covered drug is medically necessary
  - Your physician will need to do the prior authorization

Effective January 1, 2016, a number of other Non Preferred prescription drugs will no longer be paid for by the plan. For these medications there are preferred and generic alternatives available. After January 1, claims for these drugs will no longer process and the pharmacy will be sent a notice that the physician will need to do a prior authorization for medically necessary use of the non covered drug or product.

Members that have a history of purchasing these products through Caremark in the past 120 days will receive letters from Caremark notifying them of the change.

Rx Savings will also be reaching out to members affected to help them navigate the process with information on preferred options and assistance in how to talk with your physician about reviewing your options.

A complete list of the drugs that will be removed is on our website.

We understand that asking members to make changes can be difficult. Removing these non preferred drugs, many with few members using them, will allow the plan and the members to both benefit from improved pricing on the preferred drug list options.

Online Prescription Resources

- You can review prescription drugs information at:
  - Caremark.com
  - Rxsavingssolutions.com
  - Mycastlight.com/SEHP

Need help reviewing your options? You can find information on your current prescriptions as well as preferred drug options on Caremark.com. You can log on, text or call Rx Savings and work with a pharmacist or pharm tech to review your options. You can review prescription drug options on the Castlight website as well.

Additions to the Discount Tier

- Nasal steroids will become discount tier items effective 1/1/16
  - There are two quality OTC nasal steroid products now available
    - Nasacort
    - Flonase

Beginning January 1, nasal steroids like antihistamine products will be in the discount tier. Members will be able to purchase them at the Caremark discount rate but the plan will no longer cover them.

The reason for this change is the availability of two of the main nasal steroid options over the counter:

- Nasacort
- Flonase

Anticipated 2016 Generic Releases

- 1st Quarter
  - Gleevec
  - Coreg CR
- 2nd Quarter
  - Crestor
  - Nuvigil
- 3rd Quarter
  - Zegerid Susp
- 4th Quarter
  - Azor
  - Benicar
  - Benicar HCT
  - Seroquel XR
  - Zetia

- These are just a few of the drugs scheduled to go generic next year.
- We encourage members to switch to generic as soon as they are released. Generic drugs save you and the plan money.
- A full list is posted on the SEHP web site for those interested.

Eligibility Change

- The regulations governing eligibility were updated earlier this year to allow a family membership that includes two married employees covered under the SEHP to elect a family plan.
  - Employees can still elect two separate plans but now have the option of one family plan
  - Double coverage for spouse or dependents is prohibited
  - If family coverage is elected the deductibles, OOPs and HSA contributions are at the family level

- The regulations that govern eligibility for coverage were updated this year to allow employees that are married to elect to be covered under one family plan.
- Employees can decide how they want to be covered, but employees and dependent children may only be covered once under the SEHP regardless of whether the employer is the State of Kansas or a Non State entity covered under the plan.
- If the family benefit is elected, the plan is the same as for any other employee with a family plan.
- The employee that enrolls the family will be the primary member and would responsible for paying the family premium.
- Contributions to the HSA would be at the family level and paid by the employing agency or group.

Selecting Your Health Plan

- Pick a plan design (A or C)
  - Which plan design provides the coverage you and your family need?
  - What is the total plan cost?
    - Premiums + Deductible + Coinsurance = Total Out Of Pocket
- Review the Provider Networks
  - Both of the medical vendors uses a different provider network

aetna

BlueCross BlueShield of Kansas

Open Enrollment is your opportunity to decide how you want to finance your healthcare for the upcoming year. We encourage you to review the plan design options. Look at the coverage and the out of pocket cost of each plan design and select an option, A or C.

•Each of our health plan vendors offers their own unique provider networks. Being a network provider means that the health care professional has agreed to accept the vendor's allowed charge as payment in full. The provider agrees to write off any difference between what they charge and what the health plan allows.

•You are free to use any provider that you wish; however, if you use a provider that is not part of your health plan's networks, it will cost you more out of your pocket. Non network providers do not have to accept the health plan's allowed charge and can bill you for the difference.

•Make sure you review the networks before deciding on a medical vendor.

Plan A

2016 Network

Medical*	
Deductible	$400/$800
Coinsurance	20%
PCP Office Visit	$30 Copay
Specialist Office Visit	$50 Copay
Pharmacy*	
Coinsurance	20%/35%/60%
Special Case Meds	$75 /30 day
Combined Out of Pocket (OOP) Max*	
Medical & Pharmacy	$4,750/$9,500

2016 Non Network

Medical *	
Deductible	$600/$1,800
Coinsurance	50%
Out of Pocket (OOP) Max*	
Non Network - Medical Only	$4,750/$9,500

***Note:** Discount tier and non covered items do not count toward your Deductible, Coinsurance or OOP Max

- Medical services are subject to a $400 deductible for one person and a maximum of $800 for a family.
- Your out of pocket cost for network deductible, coinsurance and copays along with your prescription drug coinsurance & copays all are added together until you meet the plan Out Of Pocket (OOP) maximums. Once you meet the OOP maximum, additional covered network services are paid at 100% for the remainder of the plan year.
- Services for network and non network care have different benefits and accumulate toward separate OOP maximums. To maximize your benefits and limit your out of pocket costs, use only network providers when possible.
- For non network services, in addition to any amount above what the plan allows, you will be responsible for the deductible and coinsurance until you reach the OOP Max for Non Network services.

Plan A Prescription Drug Plan

Drugs	Coverage Level
Generic	20% Coinsurance
Preferred Brand Name Drugs	35% Coinsurance
Special Case Medications	25% Coinsurance to a Max of $75 per 30 day supply
Non Preferred Brand Name Drugs	60% Coinsurance
Discount Tier	You pay 100% of discount cost. Do not count toward your OOP

Note: Non covered prescription items do not count toward your OOP maximum.

- There are no changes to the coverage tiers under the Plan A pharmacy program, but there are changes to the drugs covered under the plan. Be sure you review any letters or communications sent to you about pharmacy changes from Caremark or Rx Savings.
- On Plan A, your prescription drugs are subject to Coinsurance. Generic drugs are your best buy and have the lowest OOP cost.
- Discount Tier drugs are not considered covered drugs and are only eligible for the discount. These will always be paid for 100% by the member – even after the deductible is satisfied.
- Members should review the preferred drug list options with their providers to find the most cost effective options. You may also want to use the transparency tools from Castlight and Rx Savings to help you reduce your pharmacy spend.

Plan C

Network

Medical & Pharmacy*	
Deductible	$2,750/$5,500
Coinsurance	None
Combined Out Of Pocket Max	$2,750/$5,500

Non Network

Medical	
Deductible	$2,750/$5,500
Coinsurance	20%
Out Of Pocket Max	$4,100/$8,200

***Note:** Discount tier and non covered items or services do not count toward Deductible or OOP Max

- On Plan C, all of your covered medical and pharmacy claims are subject to the deductible.
- If you use network providers, once your deductible is met, additional covered services with network providers and prescription drugs are covered at 100% for the remainder of the calendar year.
- For non network services, in addition to any amount above what the plan allows, you will be responsible for the deductible and coinsurance until you reach the OOP Max for Non Network services.

Plan C Prescription Drug Plan

- Covered drugs are subject to the Network Plan C Deductible
- After the Deductible, the plan pays for covered prescription drugs at 100% of allowed charge
- Uses same Preferred Drug List as Plans A

CVS CAREMARK

- On Plan C, prescription drugs are subject to the overall plan deductible and then paid at 100% once the deductible has been satisfied.
- The Preferred Drug List is the same as the one used for Plans A. It is available on Caremark.com.
- There are changes to what drugs are eligible for coverage on the plan. Please review any letters or communications you receive on these changes from Caremark or Rx Savings.
- Discount Tier drugs are not considered covered drugs and are only eligible for the discount. These will always be paid for 100% by the member – even after the deductible is satisfied.

Plan C Health Savings Account

- An employee-owned bank account for saving money to pay for your current or future medical expenses
- Portable - The account and the money belong to you
- Unspent HSA funds roll over and accumulate year to year and can be invested
- HSA funds can be used to pay expenses of you and your tax qualified dependents
- The HSA contribution level is determined by the enrollment coverage level

OPTUM Bank℠

- Plan C includes a Health Savings Account (HSA). This a way for the employee and employer to set aside funds to pay for health care services.
- The HSA is an employee-owned bank account and funds can be rolled from year to year if not spent.
- You can only contribute to an HSA while you are enrolled in a qualified high deductible health plan. You can spend it anytime.
- Members can invest their HSA funds in a variety of investment options.
- This is your account and your funds. The account and the funds in it belong to the employee and go with you if you leave State service or if you switch to another health plan at a future open enrollment.
- As long as the money is spent on healthcare for you or your qualified dependents, the money is not taxable to you.
- You can set aside funds using pre-tax payroll deduction for additional tax savings.
- The Employer contribution will be determined based on your coverage level at the time of the payment.

HSA Eligibility

- The following Employees are eligible to have an HSA:
  - You must be covered by Plan C, a Qualified High Deductible Health Plan (QHDHP)
  - You must have no other health coverage that isn't an HDHP except what is permitted under "Other Coverage" defined by the IRS
    - Ex. Accidental injury, Cancer or similar plans
  - You are not enrolled in Medicare or TRICARE
  - You cannot be claimed as a dependent on someone else's tax return

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The IRS has set the guidelines for when an employee can enroll and contribute to a HSA. These rules apply only to the employee and not covered family members.

- You must be enrolled in a QHDHP to contribute to an HSA.
- You may not have other medical type of health coverage. You may be covered under another QHDHP. Cancer and other limited coverage plans are fine.
- You may not be enrolled in Medicare or TRICARE.
- You may not be claimed as a dependent on someone else's tax return.

HSA Eligibility Update

- Effective January 1, 2016, employees who use the VA for service-related health care are no longer ineligible for an HSA account
  - *Surface Transportation and Veterans Health Care Choice Improvement Act of 2015* Public Law 114-41

OPTUM Bank™

Veterans that were using the VA for service-related health care have in the past been excluded from eligibility for an HSA. That changed this year with the passage of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. Using the VA for care no longer excludes an employee from having an HSA.

Note: Coverage under TRICARE remains a disqualifier for an HSA.

State HSA Funding

	Single	Family
Employer (ER) Contribution * $1,500/$2,250	$750 & $750	$1,125 & $1,125

- State's HSA contribution will be made in two payments:
  - First pay period in January
  - First pay period in July
  - The contribution will now track with the coverage level at the time of the payment
- 2015 Plan A members with carryover HCFSA funds:
  - Any balance in your Health Care FSA will be transferred to Limited Purpose FSA for use on vision and dental expenses in 2016

* Contribution amounts shown are for full time employees

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The State will make two (2) equal contributions into the employee's HSA:

- The first half of the employer payment will be deposited into your account the first pay period in January.
- The second half of the employer payment will be deposited into your account the first pay period in July.
- If you are currently enrolled in Plan A and have a Health Care Flexible Spending account on January 1, 2016, your balance up to $500 will roll over into a Limited Purpose FSA that you can spend on vision or dental expenses.

Plan C HSA Contributions

HSA Account	Single	Family
Annual Maximum HSA Contribution	$3,350	$6,750
ER Maximum HSA Contribution	$750 & $750	$1,125 & $1,125
EE Minimum $25 Contribution Annually	$600	$600
Available Employee (EE) Contributions*	$25 to $77.08	$25 to $187.50
Additional over age 55 "Catch up" amount	$1,000	$1,000

- Based on full time employees with 24 pay period deductions

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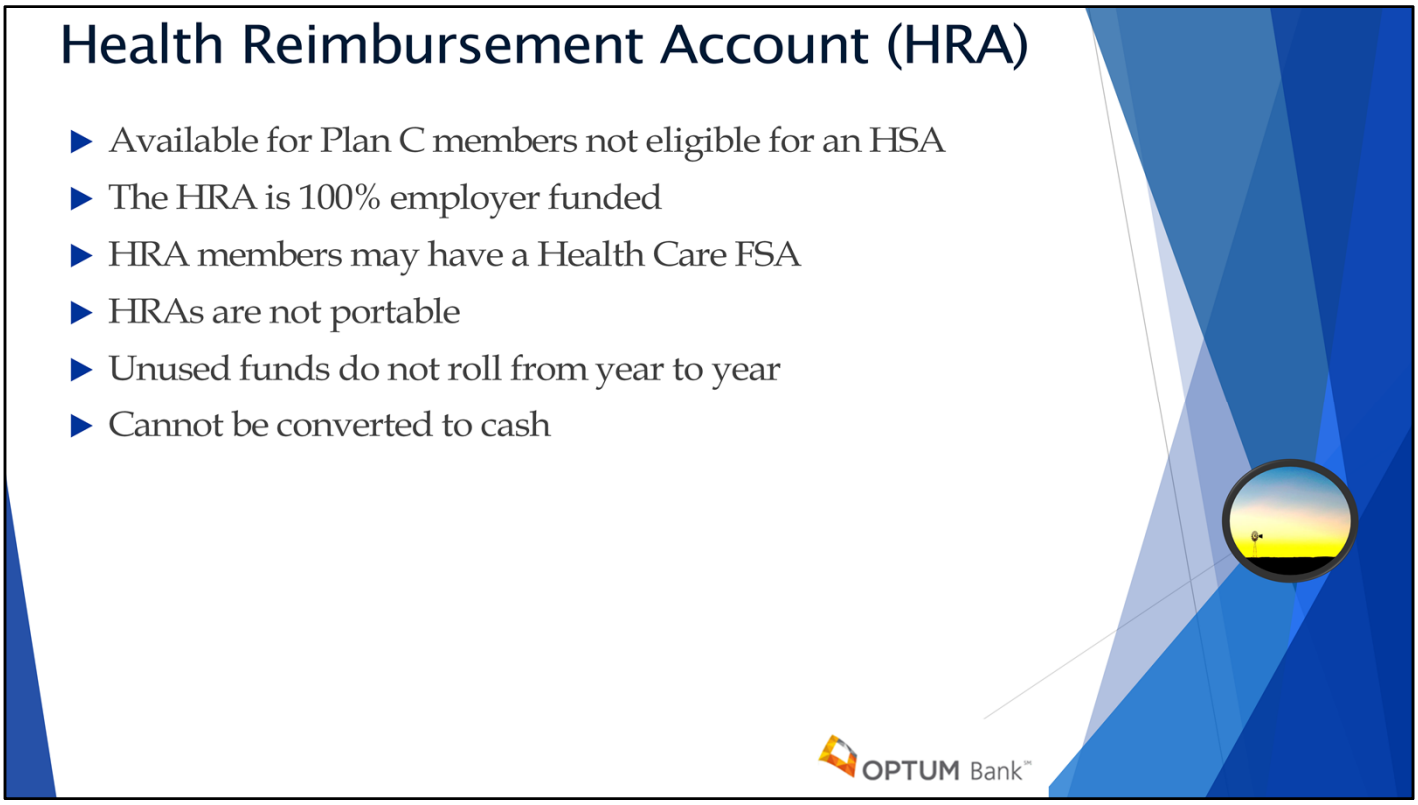
The total annual maximum amount is the total amount that you and your employer can set aside each year into an HSA. The State is going to put a total of $1,500 into your Health Savings Account for single coverage over the course of the year ($2,250 if you choose family coverage).

You will be asked to set aside a minimum of $25 per pay period by payroll deduction. Over the course of the year your contribution will result in $600 being added to your account.

You can elect to contribute more to your HSA, but the total contribution to the HSA by the State and by you cannot exceed the maximum allowed by the IRS of $3,350 for a single plan and $6,750 for a family plan.

Members over age 55 may use the "Catch Up" provision to set aside an additional $1,000 per year into their HSA.



For employees who are not eligible for an HSA, we will be offering a Health Reimbursement Account.

- HRAs are 100% employer-funded - No employee contributions are allowed.
- Employees with an HRA may have a Health Care FSA.
- HRAs are not portable:
    - Unused funds do not roll from year to year
    - Cannot be converted to cash
    - Unused funds cannot be assigned to a beneficiary

State HRA Funding

	Single	Family
Employer (ER) Contribution* $1,500/$2,250	$750 & $750	$1,125 & $1,125

- State's HRA contribution will be made in two payments:
  - First pay period in January
  - First pay period in July
  - Contribution will follow coverage level

* Contribution amounts shown are for full time employees

OPTUM Bank™

The State will pay HRA funding in two (2) equal contributions:

- The first half of the employer payment will be deposited into your account the first pay period in January.
- The second half of the employer payment will be deposited into your account the first pay period in July.
- HRAs may be used in conjunction with a healthcare flexible spending account.

Stormont–Vail Preferred Lab Benefit

- All Plan A & C members may use Stormont-Vail draw sites
- Plan A - 100% coverage for eligible outpatient lab services
- Plan C – Discounts on eligible outpatient lab services
- Labs drawn at other Cotton-O'Neil locations may be included if by network providers
- Show your medical ID Card to access benefit

BCBS Members: The local BCBS plan of the physician that ordered the lab test will process the lab claim. If your provider is outside of BCBS of Kansas area, Stormont-Vail may not be a network provider and the claim may be subject to non network benefits.

Stormont-Vail HealthCare

• Stormont-Vail HealthCare is a regional preferred lab vendor for Plans A and C.

• On Plan A, when you have covered outpatient lab work performed and billed by Stormont-Vail, the plan pays 100 percent of the cost of the services. The plan can pay the additional amounts due to the negotiated discounts.

•Plan C members receive discounts on services until the Plan C deductible is satisfied and then covered services are paid at 100 percent.

•BCBS members - please note that claims for lab services are processed by the local plan of the doctor that ordered the testing. So if they are outside the BCBS of Kansas area, Stormont-Vail or Quest for that matter, may not be a network provider and you may incur additional expenses. This is a national BCBS Association rule and not one the local BCBS plan has any control over.

Quest Diagnostics Preferred Lab Benefit

- Plan A - 100% coverage of eligible outpatient lab tests
- Plan C – Discount on eligible outpatient lab services
- Statewide & nationwide preferred lab vendor
  - Your doctor can draw the sample and send to Quest
  - You can visit Quest's website for collection sites
  - Services must be performed and billed by Quest
  - Online appointment scheduling available
- Use Your Quest ID card or medical ID card

www.labcard.com

BCBS Members: The local BCBS plan of the physician that ordered the lab test will process your lab claim. If your provider is outside of BCBS of Kansas area, Quest may not be a network provider for that BCBS plan and the claim may be subject to non network benefits.

Quest Diagnostics LabCard

- Quest Diagnostics is the statewide preferred lab vendor for Plans A and C.
- For Plan A, when you have covered outpatient lab work performed and billed by Quest, the plan pays 100 percent of the cost of the services. The plan can pay the additional amounts due to the negotiated discounts with Quest.
- Plan C members receive discounts on services until the Plan C deductible is satisfied and then covered services are paid at 100 percent.
- Any provider may use the Quest lab service by calling Quest to pick up the sample. You and your provider will decide whether or not to do so.
- Visit Quest's website for a complete list of Quest collection sites.

Dental Coverage

- Plan pays in full for 2 exams & cleanings
- Annual benefit maximum: $1,700 per person per year

Benefit Level	PPO	Premier	Non Network
Preventive Services	Covered in full	Covered in full	Allowed amount covered in full
Basic Benefit			
Basic Restorative	50%	50%	50%
Enhanced Benefit			
Basic Restorative	20%	40%	40%

DELTA DENTAL

- There are no changes to the dental plan for 2016.
- The plan continues to cover two preventive cleanings per person per year.
- Members that have had a cleaning or exam in the prior 12 months and need basic restorative care will be at the Enhanced benefit level.
- Members who haven't had a cleaning or exam will be at the Basic benefit level.
- Orthodontic coverage is available and is limited to $1,000 per person per lifetime.
- The annual maximum benefit paid per person per year is unchanged at $1,700.

Vision Benefits

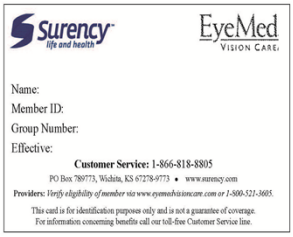
Basic Plan	
Office Visit Copay	$50
Materials Copay	$25
Frame Allowance	$100
Lenses: single vision, standard bifocal, trifocal or lenticular	100%
Contact lenses Allowance	$150
Contact Fitting Fee Copay	$35

Enhanced Plan - Covers everything in the Basic Plan PLUS…….	
Frame Allowance	$150
High Index Allowance	Up to $116
Polycarbonate lenses	Covered in Full
Progressive lenses Allowance	Up to $165
Scratch & UV coating	Covered in full

Surency life and health

The vision programs will now be offered through Surency Life and Health Insurance Company, a wholly owed subsidiary of Delta Dental of Kansas. Both the Basic and Enhanced plans will continue to be offered. Basic covers a pair of standard eyeglasses or contact lenses. The Enhanced Plan includes everything Basic offers plus offers a higher frame allowance and provides coverage toward lens enhancements like progressive lenses (no line bifocals).

Surency Insight Network



- Our Partner - **EyeMed Vision Care**
- **Surency Insight Network**
  - Combination of Retail and Independent Providers
  - Over 760 providers at more than 200 locations
  - Many Walmart Optical Centers are Network Providers
  - Non Network Walmart Stores Only:
    - All claims reimbursed at Network level of benefits
    - Members will need to file the claim
  - Search the Provider Network at: **www.surency.com/stateofkansas**

Surency life and health

- The network of providers has changes, so be sure that you review the new Surency Insight Network.
- Surency partners with EyeMed Vision on this program, but the network is the Surency Insight Network and can be found on the Surency Website.
- The network includes retail stores, chains and independent optical providers.
- Most Walmarts are part of the network; however, if the Walmart is not a network provider, Surency will still reimburse the claim at the network level.
- The other difference is that the member using a non network Walmart would need to file their own claim for reimbursement to Surency.
- Non network claims forms are available on the Surency website.

FSA Vendor

- Free FSA Debit Card - Pay for your qualified FSA expenses
- NueSynergy Mobile access to account balances & plan details
- www.KansasFSA.com access account 24/7.
- FSA Options:
  - Healthcare FSA - Limited to $2,550
  - Limited FSA (Plan C) - dental & vision expenses $2,550 limit
  - Dependent Care FSA - child care expenses $5,000 limit

NueSynergy, our flexible spending account administrator, offers a debit card to members enrolled in health care, limited or dependent care FSAs with no monthly fees. NueSynergy has a free mobile app available to make using your account easier. Their user friendly website includes a benefit calculator to help you determine the proper amount to set aside in your account as well as tools to manage your FSA account.

The maximums you can set aside this year into a flexible spending account are:

- HealthCare and Limited FSA $2,550
- Dependent Care is limited to $5,000

HealthQuest (HQ) Rewards

- You have until 11/15/2015 to earn the discount for PY 2016 of $480
- For PY 2017 the HQ Rewards discount will be $240
- The earning opportunities for PY 2017 have been updated. Examples:
  - The required health assessment is now worth 5 credits
  - New: participating in the HQ health screening events is worth 5 credits
  - New: Your non tobacco use will be credited from the health assessment
  - The complete chart will be posted online 11/16/2016

You have until November 15, 2015, to earn the $480 discount on your plan year 2016 premiums. To earn the discount, members have to complete the health assessment questionnaire (worth 10 credits) and earn 20 additional credits.

The Plan Year 2017 Premium Incentive Discount will be $240 and members have from November 16, 2015, through November 15, 2016, to earn the discount. There have been some updates to the points and more information about the new program year will be posted November 16th.

Open Enrollment Oct. 1 – 31, 2015

- Enroll online: **https://sehp.member.hrissuite.com/**
- Employees of ESU, KSU, KU, KUMC or PSU will use https://sso.cobraguard.net/seer_login.php
- HealthyKIDS program application available: https://khap.kdhe.state.ks.us/hkapplication/
- If you are adding a new dependent during open enrollment you will need to attach or scan electronic copies of:
  - Children: birth certificates
  - Spouses: marriage licenses or tax returns
- Enrollment Questions: **SEHPMembership@kdheks.gov**

Open Enrollment is your opportunity to decide which health plan you want for next year. Open Enrollment is the month of October and enrollment will again be done online in the Membership Administration Portal (MAP).

If you are adding a dependent not currently covered on the plan during Open Enrollment, you will need to provide supporting documentation to show they are eligible for the plan.

If you have questions about membership or enrollment, please send those questions to our membership staff at the email address shown.

Identification Cards

- Caremark, Delta & Surency are sending everyone enrolled new ID cards
- Aetna & BCBS Plan A members will get new cards
- Aetna & BCBC Plan C members will not be getting new cards

- Aetna and BCBS Plan A, Delta and Surency are sending everyone enrolled with them new ID cards.
- Caremark, Aetna and BCBS Plan C members will only receive new cards if they make coverage changes.

If you have questions on the FSA, HRA, HSA, Membership and Eligibility or the Enrollment portal, please send those to the membership staff directly.

If you have benefit or plan questions, please send those to the benefits mail box. The open enrollment book is available online for anyone who would like to review it on our website.

Rates Based on 24 Payroll Deductions

2016 Semi-Monthly Rates for State of Kansas Active Employees **							
Employee Category	PLAN A		PLAN C		Delta Dental	Surency Vision	
	Aetna	BCBS	Aetna	BCBS		Basic	Enhanced
Full Time							
Employee Only	$36.15	$32.68	$34.72	$28.79	$0.00	$1.98	$3.90
Employee + Spouse	$150.91	$131.09	$80.04	$68.37	$7.92	$3.88	$7.69
Employee + Children	$118.51	$103.70	$63.68	$53.35	$6.33	$3.50	$6.93
Employee + Family	$261.56	$229.50	$132.25	$115.25	$14.27	$5.41	$10.75

***If you have qualified for the HealthQuest Rewards Progrm Premium Incentive Discount, subtract $20 per pay period from the rates above to determine the amount of your discounted semi-monthly premium.*